RHC BILLING 401

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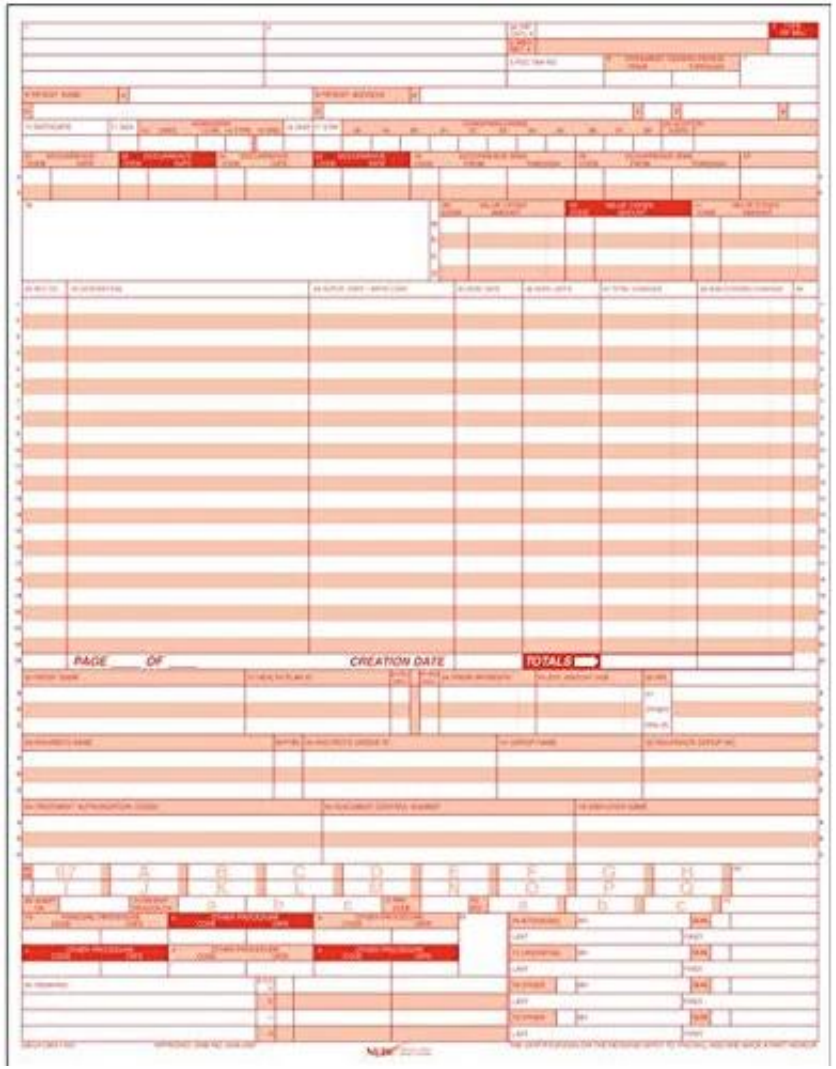
CLAIM SCENARIOS AND REMIT SAMPLES

- ✓ Baseline CG Modifier Usage
- ✓ Bundled Services/Allergy Injections
- ✓ Nursing Home Visits
- ✓ Procedures and Global Billing
- ✓ Welcome to Medicare with Clinical Visit/Same Day
- ✓ Stand-Alone Preventive with Clinical Visit
- ✓ Multiple Encounter Scenarios
- ✓ Behavioral Health and Clinic Visits on the Same Day
- ✓ Behavioral Health and Telehealth
- ✓ G2025 and Medicare Telehealth



WHAT WE ALREADY KNOW: QUALIFYING VISITS

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

RHC QUALIFYING VISIT LIST - NARRATIVE

"From April 1, 2016 through September 30, 2016, all charges for a visit must be reported on the service line with the qualifying visit HCPCS code, *minus any charges for preventive services using revenue code 052x* for medical services and/or revenue code 0900 for mental health services."

RHC Qualifying Visit List

ONE QUALIFYING VISIT – MAJORITY OF THE CARE

Modifier CG should only be used to indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible.

DIRECT SUPERVISION FOR INCIDENT-TO SERVICES

Services and supplies furnished incident to physician's services *are limited to situations in which there is direct physician supervision* of the person performing the service, except for authorized care management services (as described in section 230) which may be furnished under general supervision.

(MBPM Chapter 13; 120.1)

BILLING EXAMPLE: INCIDENT-TO SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	08/02/2021	1	$ 150.00
0636	Injection Admin	96372	08/02/2021	1	$ 20.00
0636	Toradol	J1885	08/02/2021	1	$ 30.00
0001	Total Charge				$ 200.00

- ✓ J1885 ($30.00) and 96372 ($20.00) are bundled with 99213 ($100) on the qualifying visit line.
- ✓ The total QVL Charge is $150.00; the sum of all services reported on the claim.
- ✓ The total charge line (0001) is inflated due to duplicating the injection/admin charges from the detail lines.

"ALTERNATE METHOD" SERVICE DETAIL REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	08/02/2021	1	$ 150.02
0636	Injection Admin	96372	08/02/2021	1	$ 0.01
0636	Toradol	J1885	08/02/2021	1	$ 0.01
0001	Total Charge				$ 150.04

- ✓ The Injection and Medication Charges ($20.00/$30.00) are added to the 99213 qualifying visit line.
- ✓ The detail lines are reported as $.01.
- ✓ The total charges are no longer falsely inflated.

OFFICE VISIT AND INJECTION

Remittance Advice Sample

NOVITAS SOLUTIONS
MEDICARE A
P O BOX 3103

Printed:
February 23, 2022

Standard Paper Remittance
(SPR)
Advice Notice

NPI #: 1234567890
ISSUE DATE: 02/01/22
PROD DATE: 01/31/22
CHECK/EFT #: EFT
CHECK AMT: 5643.64

REND PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COPAY	COINS	GRP/RC-AM T	PROV PD
PATIENT:	ID:				ACNT 123456		ICN: 123456789AS778			MOA: MA01 M15	
Claim Period:	120821 120821										
	120821 120821		1	96372 REV CODE 0521	0.01	0.01	0.00	0.00	0.00CO-97	0.01	0.00
	120821 120821		1	99214 CG REV CODE: 0521	230.00	230.00	0.00	0.00	46.00CO-45	104.00	80.00
	120821 120821		4	J0696 REV CODE: 0636	0.04	0.04	0.00	0.00	0.00CO-97	0.04	0.00
PT RESP: 46.00				CLAIM TOTALS:	230.05	230.05	0.00	0.00	46.00	104.05	80.00
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00				NET: 80.00	

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK
	1	230.05	230.05	0.00	46.00	104.05	80.00	0.00	5643.64

GLOSSARY: Group, Reason ,MOA, MIA, Remark and Adjustment Codes:

CODE	DESCRIPTION
2	Coinsurance Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)
PR	Patient Responsibilty. Amount that may be billed to a patient or another payee.

BUNDLED SERVICES – DIFFERENT DATES

- ✓ "…services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe." (MBPM 13; Section 120.3)

- ✓ Do NOT span dates on the "Admit From" and "Admit Through" dates. This will cause other claims submitted within those dates to reject.

BILLING EXAMPLE: BUNDLED INJECTION/DIFFERENT DATES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	08/02/2021	1	$ 180.04
0636	Allergy Injection	95115	08/02/2021	4	$ 0.04
0001	Total Charge				$ 180.08

Four weekly allergy injections @ $20.00 each were provided. An Office Visit occurred on 4.2.2020.

- ✓ Four allergy injections are bundled with the $100 charge on the 99213 qualifying visit line.
- ✓ Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

NURSING HOME VISIT REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0525	NH Visit - Established	99308CG	04/21/2021	1	$ 150.00
0001	Total Charge				$ 150.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0522	Home Visit – Moderate Est	99349CG	04/21/2021	1	$ 150.00
0001	Total Charge				$ 150.00

NURSE-ONLY VISITS

"Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an RHC or FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services."

"The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit.

Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe."

GLOBAL BILLING

- ✓ Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services.
- ✓ The RHC is paid based on its all-inclusive rate and is not subject to the Medicare global billing requirements.
- ✓ Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

✓

BILLING EXAMPLE: OFFICE VISIT PLUS PROCEDURE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 3	99213 CG	08/02/2021	1	$ 280.00
0521	Joint Injection	20610	08/02/2021		$ 0.01
0001	Total Charge				$ 280.01

- ✓ An office visit is performed in addition to a joint-injection at the same visit.
- ✓ The joint injection ($180.00) is bundled with the ($100.00) office visit charge.
- ✓ These should be bundled and submitted on the same encounter.
- ✓ The joint injection is on the QVL. If performed independently it is paid at the AIR.

BILLING EXAMPLE: PROCEDURES ONLY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	08/02/2021	1	$ 150.00
0001	Total Charge				$ 150.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Procedure	99213CG	08/02/2021	1	$ 650.01
0521	Wound Rpr < 2.5 cm	12031	08/02/2021	1	$ 0.01
0001	Total Charge				$ 650.02

PREVENTIVE SERVICES AND SAME DAY BILLING

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day."

MLN SE1039

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

BILLING EXAMPLE: IPPE PLUS OFFICE VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient III	99213CG	04/02/2020	1	$ 100.00
0521	IPPE	G0402	04/02/2020	1	$ 200.00
0001	Total Charge				$ 300.00

"Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service." RHC Reporting FAQ

STAND-ALONE ENCOUNTERS

If a “Stand Alone” encounter is the only service rendered on a particular date of service, then it will be paid at the AIR. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible may be waived, depending on the service rendered.

- ✓ Annual Wellness Visit (AWV) and Personalized Prevention Plan Services (PPPS)
- ✓ Subsequent Annual Wellness Visit
- ✓ Advanced Care Planning
- ✓ Medicare Preventive Screenings

STAND ALONE VISIT CODES

Qualifying Visit	
G0444	Depression screen annual
G0445	High intensity behavioral counseling, 30 min
G0446	Intensive behavioral therapy - Cardio diagnostic
G0447	Behavioral counseling obesity, 15 min
Q0091	Obtaining screening pap smear

OFFICE VISIT AND PREVENTIVE W. ANCILLARY

An established patient is seen and a qualifying visit of 99213 for $100 is generated. An Annual Wellness Visit was also performed for $100.00. A venipuncture was performed for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2021	1	$ 120.01
0521	AWV	G0438	04/02/2021	1	$ 100.00
0300	Venipuncture	36415	04/02/2021	1	$ 0.01
0001	Total Charge				$ 220.02

- ✓ The charge for the AWV should NOT be bundled in the 99213 line.
- ✓ The $20.00 venipuncture charge will be bundled with the 99213 charge for $100.00.
- ✓ The AWV does not result in direct reimbursement.

BILLING EXAMPLE: WELL-WOMAN EXAM

Medicare does not pay a well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091).

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	04/02/2021	1	$ 175.00
0521	Breast/Pelvic	G0101	04/02/2021	1	$ 75.00
0521	Pap Smear	Q0091	04/02/2021	1	$ 50.00
0001	Total Charge				$ 300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

PREVENTIVE PLUS CLINICAL VISIT

Remittance Advice Sample

NOVITAS SOLUTIONS
MEDICARE A
P O BOX 3103
MECHANICSBURG, PA 170551819

Printed:
February 23, 2022

Standard Paper Remittance
(SPR)
Advice Notice

NPI #: 1234567890
ISSUE DATE: 04/21/21
PROD DATE: 04/20/21
CHECK/EFT #: PMT123456
CHECK AMT: 2740.55

REND PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COPAY	COINS	GRP/RC-AMT	PROV PD
PATIENT: Smith, J					ACNT		ICN: XXXXXXXXXXXXXXXXX			MOA: MA01 M15	
Claim Period:	031221 031221										
1234567890	031221 031221		1	G0439 CG REV CODE: 0521	200.00	200.00	0.00	0.00	0.00 CO-45	113.69	86.31
1234567890	031221 031221		1	G0444 REV CODE: 0521	25.00	25.00	0.00	0.00	0.00 CO-97	25.00	0.00
1234567890	031221 031221		1	99173 REV CODE: 0521	35.00	35.00	0.00	0.00	0.00 CO-97	35.00	0.00
1234567890	031221 031221		1	99213 REV CODE: 0521	110.00	110.00	0.00	0.00	0.00 CO-97	110.00	0.00
PT RESP: 0.00				CLAIM TOTALS:	370.00	370.00	0.00	0.00	0.00	283.69	86.31
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00					NET: 86.31

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK
	1	370.00	370.00	0.00	0.00	283.69	86.31	0.00	2740.55

GLOSSARY: Group, Reason, MOA, MIA, Remark and Adjustment Codes:

CODE	DESCRIPTION
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

RHC USE OF MODIFIERS -59 AND -25

Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only a subsequent illness or injury on the same day as another visit. Modifier-25 in an RHC in interchangeable with -59!

- ✓ Modifier-59 and -25 indicate two encounters. -25 is different in an RHC. Modifier 25 or 59 is only on the SECOND line item UB-04 on a claim form.
- ✓ **RHC Pro Tip:** Modifier-25 is NOT used to distinguish an Evaluation and Management Service from a procedure.

CG MODIFIER FAQ: SUBSEQUENT ILLNESS OR INJURY

Is modifier CG reported on a ***subsequent*** visit which occurs on the same day as an earlier visit?

✓ A13. No.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a ***subsequent*** medically necessary visit?

✓ A14. No.

From A15: *Modifier 25 or 59 is reported only on the line that represents the primary reason for the subsequent visit.*

MODIFIER-59 EXAMPLE: SUBSEQUENT INJURY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2020	1	$ 350.00
521	Laceration Repair	12002 59	04/02/2020	1	$ 0.01
0001	Total Charge				$ 350.01

Modifier CG and modifiers 25/59 are NOT reported on the same service line together to indicate a subsequent medically necessary visit.

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

MEDICARE BEHAVIORAL HEALTH QUALIFIED VISITS

HCPCS	Description
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval w/Med Services
90832	Psytx Pt/Family 30 minutes
90834	Psytx Pt/Family 45 minutes
90837	Psytx Pt/Family 60 minutes
90839	Psytx Crisis Initial 60 minutes
90845	Psychoanalysis

CLINICAL VISIT AND BEHAVIORAL HEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	10/04/2021	1	$ 220.00
0900	Rx Management	90832CG	10/04/2021	1	$ 120.00
0001	Total Charge				$ 340.00

NOTE: Normally paid on separate claim forms.

BEHAVIORAL HEALTH AND SICK VISIT ON THE SAME DAY

Remittance Advice Sample

*error. Could not find relevant image

NEGATIVE PAYMENT

Remittance Advice Sample

NOVITAS SOLUTIONS
MEDICARE A
P O BOX 3103
MECHANICSBURG, PA 170551819

Printed:
February 25, 2022

Standard Paper Remittance
(SPR)
Advice Notice

NPI #: 1234567890
ISSUE DATE: 02/24/22
PROD DATE: 02/23/22
CHECK/EFT #: REMIT00539
CHECK AMT: 0.00

REND PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COPAY	COINS	GRP/RC-AMT	PROV PD
PATIENT: STARMAN, Ziggy ID: 86753091981					ACNT: 123456		ICN: 1234567989000			MOA: MA01	
Claim Period:	011022 011022										
	011022 011022	1	99214 CG	REV CODE: 0521	130.00	130.00	130.00	0.00	0.00	CO-45 17.00	-17.00
PT RESP: 130.00				CLAIM TOTALS:	130.00	130.00	130.00	0.00	0.00	17.00	-17.00
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00					NET: -17.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK
	1	130.00	130.00	130.00	0.00	17.00	-17.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, MIA, Remark and Adjustment Codes:

CODE	DESCRIPTION
1	Deductible Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)
PR	Patient Responsibilty. Amount that may be billed to a patient or another payee.

NEW REGULATION!

UPDATED RHC ENCOUNTER DEFINITION!

That’s a big deal.

§ 405.2463 WHAT CONSTITUTES A VISIT

A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio only interactions in cases where the patient is not capable of, or does not consent to, the use of technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder…

MENTAL HEALTH VISITS FURNISHED USING TELEHEALTH

Beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology.

This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, *including audio-only visits* when the beneficiary is not capable of, or does not consent to, the use of video technology.

CMS Rural Health Clinic Center

IN-PERSON VISITS

"There must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that, in general, An in-person, non-telehealth visit must be furnished at least every 12 months for these services;"

✓ CMS Rural Health Clinic Center

MENTAL HEALTH VISITS FURNISHED USING TELEHEALTH

"however, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record)

and also allow more frequent visits as driven by clinical needs on a case-by-case basis."

CMS Rural Health Clinic Center

BEHAVIORAL HEALTH CLAIMS VIA TELEHEALTH

"RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only."

CMS Rural Health Clinic Center

BEHAVIORAL HEALTH => TELEHEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90832 CG 95	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90832 CG FQ	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

G2025 ONLY

RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G-code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective.

https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

RHC – FQHC DISTANT SITE PROVIDER PAYMENT: PHE ONLY

Claims for G2025 are paid at the CY2021 rate of $99.45. The CY 2022 rate is $97.24.

CMS Rural Center 2022

RHC TELEHEALTH DISTANT SITE SERVICES:

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025	02/22/2022	1	$ 97..24
0001	Total Charge				$ 97.24

Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025. **These claims will be paid at $97.24.***

MEDICARE TELEPHONE ONLY VISITS = G2025

During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare Telehealth Service under the PFS. (See Medicare Approved Telehealth Services)

Effective March 1, 2020, these services include CPT codes ***99441, 99442, and 99443***, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025.

Prior guidance CMS had indicated that telephone only visits could only be billed as G0071 – Virtual Check-In. The ***CURRENT guidance:*** *We can adjust telephone only claims that were billed G0071 to G2025 to be paid the higher rate – back to March 1, 2020.*

See MLN SE20016. Revised January 23, 2022 https://www.cms.gov/files/document/se20016.pdf

MEDICARE *TELEPHONE ONLY VISITS*

RHCs and FQHCs ***can*** furnish and bill for these services using HCPCS code G2025. To bill for these services:

- ✓ at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
- ✓ These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

ANNUAL WELLNESS VISITS AND TELEPHONE ONLY

For the duration of the public health emergency, the AWV may be administered using audio-only technology, if a video connection with the patient is not possible. If the patient can self-report elements of the AWV (i.e., height. weight, blood pressure, other measurements deemed appropriate based on medical and family history), those measurements may be included and recorded in the medical record as reported by the patient.

SE20016

CS MODIFIER FOR COVID-RELATED SERVICES: CO-INSURANCE MUST BE WAIVED

For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries.

- ✓ For COVID-related services in which the coinsurance is waived, RHCs and FQHCs must report the “CS” modifier on the service line.
- ✓ The CS-modifier NOW also applies to preventive services rendered via telehealth, where patient cost sharing should not apply.

TELEHEALTH CO-INSURANCE AND DEDUCTIBLE

Medicare WILL apply cost-sharing (co-insurance and deductible) to Telehealth services unless the are COVID-related, or preventive services.

TELEHEALTH CRYSTAL BALL

G2025 will be extended for 1-2 years after the end of the Public Health Emergency.

SE20016 REVISED: CS – MODIFIER

CS - Cost-sharing waived:

for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test, **and/or**

for **cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics** and Federally Qualified Health Centers during the COVID-19 public health emergency.

TELEHEALTH REFERENCE

Centers for Medicare and Medicaid Services. MLN 20016 Revised. "New and Expanded Flexibilities for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)". February 23, 2021.

RHC - CMS RESOURCES

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and_Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

RHC - CMS RESOURCES

State Operations Manual Appendix G (Updated 2.10.20)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) FAQ

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

CMS QUICK REFERENCE GUIDE

See Rural Providers & Suppliers Billing MLN006762 July 2021.

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